Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WELLNESS CENTER
2300 SOUTH BELL SUITE 20
AMARILLO TEXAS 79106

Respondent Name
AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-06-3210-01

MFDR Date Received
SEPTEMBER 12, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the Request for Reconsideration Letter dated April 8, 2005:
"We called and received a verbal ok to continue the physical medicine… We did a total of 12 weeks of physical medicine three times a week. We had done 7 weeks of therapy before the re-injury on February 10, 2005. At that time we did do 5 more weeks of therapy. We do not feel this is unnecessary medical treatment and would like all charges reconsidered."

Amount in Dispute: $2,692.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No further payment was recommended. Please refer to the attached re-evaluation and explanation of benefits reports and physician's retrospective review attached hereto."

Response Submitted by: Hoffman Kelley, L.L.P

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 8, 2005 to March 30, 2005	Physical Therapy, office visits, Injections,	$2,692.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.308 sets out the procedures for resolving independent review of medical necessity disputes.
3. Per 28 Texas Administrative Code §133.4 sets out the procedures for Written Notification to Health Care Providers of Contractual Agreements for Informal and Voluntary Networks.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 28, 2005 for dates of service February 8, 9, 10, 11, 14, 16, 18, 2005.
- 777 – Based on the diagnosis, treatment patterns and/or number of visits, the treatment exceeds our physician parameters. Refer to Dr. Report.
- U – Unnecessary Treatment (W/O peer review)

Explanation of benefits dated March 3, 2005 for dates of service February 23, 25, 2005.
- 777 – Based on the diagnosis, treatment patterns and/or number of visits, the treatment exceeds our physician parameters. Refer to Dr. Report.
- U – Unnecessary Treatment (W/O peer review)

Explanation of benefits dated March 14, 2005 and May 6, 2005 for dates of service February 23, 25 and March 2, 2005.
- 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- 5059 – Based on the diagnosis, treatment patterns and/or number of visits, the treatment exceeds our physician parameters. Refer to Dr. Report. If you disagree with this decision, you may request reconsideration. If the original decision is upheld, you may request an independent review in accordance with Texas DWC Act 413.031 and adopted rule §133.308 within 45 days of the denial. A request for independent review must be filed in the form and manner prescribed by TDI. The IRO request form may be obtained from www.tdi.state.tx.us or by contacting TDI-HWCN.
- 5081 – Reduction or denial of payment resulting after a reconsidera6tion was completed.

Explanation of benefits dated October 11, 2005 for dates of service February 28 and March 2, 2005.
- 18 – Duplicate claim/service
- 247 – A payment or denial has already been recommended for this service
- 5083 – This charge is being disallowed as additional/supporting documentation is required to clarify service/supply rendered. Please resubmit to expedite processing of your claim, please attach a copy of your original bill when submitting the requested documentation

Explanation of benefits dated March 10, 2005 for dates of service March 2, 2005
- 777 – Based on the diagnosis, treatment patterns and/or number of visits, the treatment exceeds our physician parameters. Refer to Dr. Report.
- U – Unnecessary Treatment (W/O peer review)

Explanation of benefits dated March 15, 2005 for dates of service March 4, and March 7, 2005.
- 777 – Based on the diagnosis, treatment patterns and/or number of visits, the treatment exceeds our physician parameters. Refer to Dr. Report.
- U – Unnecessary Treatment (W/O peer review)

Explanation of benefits dated March 17, 2005 for dates of service March 8, 2005 to March 11, 2005
- 777 – Based on the diagnosis, treatment patterns and/or number of visits, the treatment exceeds our physician parameters. Refer to Dr. Report.
- U – Unnecessary Treatment (W/O peer review)

Explanation of benefits dated April 11, 2005 for dates of service March 25, 2005 to March 30, 2005
- 777 – Based on the diagnosis, treatment patterns and/or number of visits, the treatment exceeds our physician parameters. Refer to Dr. Report.
- U – Unnecessary Treatment (W/O peer review)

Issues

1. Did the requestor have a contractual arrangement with the insurance carrier for the dates of service in dispute?
2. Did the requestor submit payment for an IRO review for disputed dates of service requestor February 8, 2005 through February 25, 2005 and March 2, 2005 through March 30, 2005?
3. Did the requestor submit documentation with the dispute for date of service February 28, 2005?
4. Is the requestor entitled to reimbursement?

Findings

1. On August 30, 2012 the Division requested from the respondent (1) a copy of the contract between American Home Assurance and the informal/voluntary network, (2) a copy of the contract between the informal/voluntary network and the healthcare provider, and (3) documentation to support that the healthcare provider was notified of the contract. The respondent replied on September 12, 2012 stating that "There was not PPO(informal/voluntary network) that was applied…..Therefore, It appears that the above would not be applicable…." The Division concludes that there was no contractual arrangement in effect for the services in dispute. For this reason the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code §133.308, non-compliance by the healthcare provider to pay the IRO fee pursuant to this Order will result in an immediate dismissal…" The healthcare provider did not submit payment to the IRO for a medical necessity determination of disputed dates of service February 8, 2005 through February 25, 2005 and March 2, 2005 through March 30, 2005. Therefore, per 28 Texas Administrative Code §133.308, the dates of service indicated above will not be considered in this findings and no further action is required by Medical Fee Dispute Resolution.
3. Per the explanation of benefits dated 10/11/2005, disputed date of service February 28, 2005 was denied/reduced by the insurance carrier with denial reason code "5083 – This charge is being disallowed as additional/supporting documentation is required to clarify service/supply rendered. Please resubmit. To expedite processing of your claim, please attach a copy of your original bill when submitting the requested documentation." Review of the dispute file finds that the requestor submitted no documentation to clarify the service/ supply rendered.
4. Review of the submitted documentation finds that the requestor has not submitted documentation for review in order for medical fee dispute resolution to make a determination on whether the charges rendered on February 28, 2005 met the documentation requirements. Therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 24, 2013 Date

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.